ConnectVirginia
Advancing Virginia's Health Care

Newborn Screening Participant Form – Exhibit A

Participant Information

Name of Hospital/Provider _____

Address _____

City_____ State_____ Zip Code_____

Participant Type:

- ☐ Hospital
- ☐ Physician
- ☐ Service Provider (i.e. OZ Systems)

Participant - Technical Point of Contact

Primary Contact_____

Phone_____ Email_____

Secondary Contact_____

Phone_____ Email_____

Participant - Nursery Point of Contact

Primary Contact_____

Phone_____ Email_____

Secondary Contact_____

Phone_____ Email_____

Participant - Lab Point of Contact

Primary Contact_____

Phone_____ Email_____

Secondary Contact_____

Phone_____ Email_____

Information Required for Data Exchange

1. Facility Name (Participant): _____
2. Facility OID (For Participant): _____
3. DCLS-assigned Submitter Code: _____
   (*Same as currently entered on NBS Dried Bloodspot Card*)
4. Does your organization intend to use OZ systems as the third-party service provider for NBS Data Exchange with DCLS?

   ☐ Yes
   ☐ No

IF your answer to #4 was YES, please skip to #9. You do not need to fill out #5-8 as those data elements will be provided by your designated third-party service provider.

5. Sending Application Name: _____
6. Sending Application OID: _____
7. Transport supported for Data Exchange (*Select one*):

   ☐ SFTP (please enter IP address of server uploading SFTP messages to ConnectVirginia)_____
   ☐ HTTPS (please enter Domain name connecting to ConnectVirginia)
   _____

8. Preferred format for SSL certificate:

   ☐ .pem
   ☐ .p12
   ☐ Other (please specify) _____

9. Can electronically send and/or receive (*Select all that apply*):

   ☐ NBS Orders (NBSORDERS)
   ☐ NBS Results (NBRESULTS)

10. From the sending application, can generate a bar coded label displaying **ALL** fields currently on the NBS Dried Bloodspot Card?

    ☐ Yes
    ☐ No